Worksheet A: Chart Reviews of Patients Who Were Readmitted

Conduct chart reviews of the last five readmitted patients. Reviewers should be physicians or nurses from the hospital and community settings. Reviewers should not look to assign blame, but rather to discover opportunities to improve the care of patients.

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Question	Patient #1	Patient #2	Patient #3	Patient #4	Patient #5
Number of days between the last discharge and this readmission date?	_____ **days**	_____ **days**	_____ **days**	_____ **days**	_____ **days**
Was the follow-up physician visit scheduled prior to discharge?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
If yes, was the patient able to attend the office visit?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Were there any urgent clinic/ED visits before readmission?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Functional status of the patient on discharge?	**Comments:**	**Comments:**	**Comments:**	**Comments:**	**Comments:**
Was a clear discharge plan documented?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Was evidence of “Teach Back” documented	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
List any documented reason/s for readmission	**Comments:**	**Comments:**	**Comments:**	**Comments:**	**Comments:**
Did any social conditions (transportation, lack of money for medication, lack of housing) contribute to the readmission?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

Worksheet A: Reflective Summary of Chart Review Findings

What did you learn?

What trends or themes emerged?

What, if anything, surprised you?

What new questions do you have?

What are you curious about?

What do you think you should do next?

What assumptions about readmissions that you held previously are now challenged?

Worksheet B: Interviews with Patients, Family Members, and Care Team Members
If possible, conduct the interviews on the same patients from the chart review. Use a separate worksheet for each interview.

Ask Patients and Families:

How do you think you became sick enough to come back to the hospital?

Did you see your doctor or the doctor's nurse in the office before you came back to the hospital?

Yes ☐ If yes, which doctor (PCP or specialist) did you see?

No ☐ If no, why not?

Describe any difficulties you had to get an appointment or getting to that office visit.

Has anything gotten in the way of your taking your medicines?

How do you take your medicines and set up your pills each day?

Describe your typical meals since you got home.

Ask Care Team Members:

What do you think caused this patient to be readmitted?

After talking to the provider and the care team about why they think the patient was readmitted, write a brief story about the patient's circumstances that contributed to the readmission:

Worksheet B: Summary of Interview Findings

What did you learn?

What were the most common failures discovered?

What trends or themes emerged?

What, if anything, surprised you?

What new questions do you have?

What are you now curious about?

What do you think you should do next?

What assumptions about readmissions that you held previously are now challenged?

List of Typical Failures:

Typical failures associated with patient assessment:

- Failure to actively include the patient and family caregivers in identifying needs, resources, and planning for the discharge;
- Unrealistic optimism of patient and family to manage at home;
- Failure to recognize worsening clinical status in the hospital;
- Lack of understanding of the patient's physical and cognitive functional health status may result in a transfer to a care venue that does not meet the patient's needs;
- Not addressing whole patient (underlying depression, etc.);
- No advance directive or planning beyond DNR status;
- Medication errors and adverse drug events; and
- Multiple drugs exceed patient's ability to manage.

Typical failures found in patient and family caregiver education:

- Assuming the patient is the key learner;
- Written discharge instructions that are confusing, contradictory to other instructions, or not tailored to a patient's level of health literacy or current health status;
- Failure to ask clarifying questions on instructions and plan of care; and
- Non-adherent patients (resulting in unplanned readmissions):
  a. About self-care, diet, medications, therapies, daily weights, follow-up and testing; and
  b. Caused by patient and family-caregiver confusion.

Typical failures in handover communication:

- Poor hospital care (evidence-based care missing/incomplete);
- Medication discrepancies;
- Discharge plan not communicated in a timely fashion or adequately conveying important anticipated next steps;
- Poor communication of the care plan to the nursing home team, home health care team, primary care physician, or family caregiver;
- Current and baseline functional status of patient rarely described, making it difficult to assess progress and prognosis;
- Discharge instructions missing, inadequate, incomplete, or illegible;
- Patient returning home without essential equipment (e.g., scale, supplemental oxygen, or equipment used to suction respiratory secretions);
- Having the care provided by the facility unravel as the patient leaves the hospital (e.g., poorly understood cognition issues emerge); and
- Poor understanding that social support is lacking.

Typical failures following discharge from the hospital:

- Medication errors;
- Discharge instructions that are confusing, contradictory to other instructions, or are not tailored to a patient's level of health literacy;
- No follow-up appointment or follow-up needed with additional physician expertise;
- Follow-up too long after hospitalization;
- Follow-up is the responsibility of the patient;
- Inability to keep follow-up appointments because of illness or transportation issues;
- Lack of an emergency plan with number the patient should call first;
- Multiple care providers; patient believes someone is in charge;
- Lack of social support; and
- Patient lack of adherence to self-care, e.g., medications, therapies, daily weights, or wound care because of poor understanding or confusion about needed care, transportation, how to get appointments, or how to access or pay for medications.